

FORM 22/AUTHORIZATION TO RELEASE MEDICAL RECORDS - *Use with Questions 22-24.*  
*Provide a separate Form 22 for each treatment provider.*

Upon presentation of the original or a photocopy of this signed authorization,

I,

(Applicant's/Patient's Name)

Social Security No.

authorize (Name and Address of Institution, Doctor, or Treatment Provider):

to provide without limitation to the Supreme Court of Missouri and the Board of Law Examiners, for the purpose of investigating my character and fitness to practice of law, all information, including copies of psychological and/or medical records, concerning advice, care or treatment provided to me during the period from \_\_\_\_\_ to \_\_\_\_\_ and relating to treatment for:

I hereby release, discharge and exonerate the Institution, Doctor, or Treatment Provider listed above and their agents and representatives so furnishing information and records from any and all liability of every nature and kind arising out of their provision of records pursuant to this Authorization.

This Authorization is subject to revocation at any time except to the extent that the Institution, Doctor, or Treatment Provider which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate one year after the date it is signed.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

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Signature of Applicant (**Sign in ink**)

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

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Notary Public (**Sign in ink**)

[Seal or Stamp must be affixed to each original]